

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/20/2012
NAME OF PROVIDER OR SUPPLIER INDEPENDENT LIVING CLUB		STREET ADDRESS, CITY, STATE, ZIP CODE 6038 W 25TH ST INDIANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00113134.</p> <p>Complaint IN00113134 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: August 20, 2012</p> <p>Facility number: 001132 Provider number: 001132 AIM number: NA</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: Residential: 55 Total: 55</p> <p>Census payor type: Other: 55 Total: 55</p> <p>Sample: 3</p> <p>Independent Living Club was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00113134.</p> <p>Quality review 8/20/12 by Suzanne Williams, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

BIBF11

If continuation sheet 1 of 1